AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

e. Emergency hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/ / Provided: / / No limitations / / With limitations*

/ / Not provided. SEE ITEM 26.

*Description provided on attachment.

STATE ARKANSAS
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SUPERSEDES: TN 91-H3

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(3) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after March 1, 2000, public transportation services in Faulkner, Lonoke and Pulaski counties are available when provided by an enrolled Medicaid public transportation provider to an eligible Medicaid recipient being transported to or from a medical facility to receive medical care services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical facility or from the medical facility to the point of delivery. The following benefit limits are established. One unit of service = 1 mile. The benefit limits do not apply to EPSDT recipients.

- **Public Transportation, Taxi, Intra-City, One Way - may be billed once per day, per recipient for a maximum of 15 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.**

- **Public Transportation, Taxi, Intra-City, Round Trip - may be billed once per day, per recipient for a maximum of 30 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.**

- **Public Transportation, City-to-City - may be billed once per day, per recipient for a maximum of 50 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.**

- **Public Transportation, ADA Accessible Van, Intra-City, One Way - may be billed once per day, per recipient for a maximum of 15 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.**

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

a. Transportation (Continued)

(3) Non-Emergency (Continued)

(a) Public Transportation (Continued)

- **Public Transportation, ADA Accessible Van, Intra-City, Round Trip - may be billed once per day, per recipient for a maximum of 30 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.**

- **Public Transportation, ADA Accessible Van, Intrastate Authority - may be billed once per day, per recipient for a maximum of 50 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.**

(b) Non-Public Transportation

Effective for dates of service on or after March 1, 2000, non-public transportation services in Faulkner, Lonoke and Pulaski counties are available when provided by an enrolled Medicaid transportation provider to an eligible Medicaid recipient transported to or from a medical provider to receive medical services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical service delivery site and from the medical service delivery site to the recipient's return destination.

The following benefit limits are established. The benefit limits do not apply to EPSDT recipients.

This service may be billed once per day, per recipient for a maximum of 300 miles per date of service.

STATE Arkansas	
DATE REC'D 2/14/00	
DATE APP'VD 2/25/00	A
DATE EFF 3/1/00	
HCFA ID 99-30	

SUPERSEDES: TN. None - New Page

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
- __ State Approved (Not Physician) Service Plan Allowed
- X Services Outside the Home Also Allowed
- X Limitations Described on Attachment

___ Not Provided.

STATE Arkansas
DATE RECD 5/14/97
DATE APPVD 8/12/97
DATE EFF 9/1/97
HCFA 179 97-03

A

SUPERSEDES: TN. 92-41

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1a

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 1992

CATEGORICALLY NEEDY

1. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the Professional Review Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The Professional Review Organization (PRO) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, a benefit limit of 20 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. The benefit limit for State Fiscal Year 1992 will be calculated beginning with dates of service on or after January 1, 1992.

Inpatient hospital services required for corneal transplants and renal transplants are subject to the MUMP procedure and the 20-day benefit limit. Refer to Attachment 3.1-E, Page 1.

Inpatient hospital services required for heart transplants, liver transplants and non-experimental bone marrow transplants are excluded from the MUMP procedure and the 20-day benefit limit. Refer to Attachment 3.1-E, Pages 2 and 3.

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DATE RECD DEC 30 1991
DATE APP'D JUL 29 1992
DATE EFF JAN 01 1992
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Inpatient hospital services required for pancreas/kidney transplants, single lung transplants and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 4, 5 and 6.

1. **Inpatient Hospital Services**

   A. **Rehabilitative Hospital**

      1. **Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.**

STATE Arkansas
DATE REC'D 6-28-99
DATE APPV'D 9-17-99
DATE EFF 9-1-99
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A

SUPERSEDES: NONE (NEW PAGE)

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 1997

CATEGORICALLY NEEDY

2.a. Outpatient Hospital Services

(1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:

- Emergency services
- Outpatient surgical procedures
- Non-emergency services
- Therapy/treatment services

Emergency Services

Prior to payment, emergency services must be approved by the Professional Review Organization (PRO). **The determination of an emergency medical condition will be in compliance with Section 1867 of the Social Security Act.**

Non-emergency services may be necessary in the outpatient hospital setting when qualified physicians are not available in their offices or walk-in clinics to carry out the necessary treatment.

STATE Arkansas
DATE REC'D 01-13-97
DATE APPV'D 01-22-97
DATE EFF 03-01-97
HCFA 179 97-01

A

SUPERSEDES: TN • 96-12

2.a. Outpatient Hospital Services (Continued)

Since each emergency service must be approved prior to payment, no additional benefit limitations are imposed.

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- **Dialysis**
- **Radiation therapy**
- **Chemotherapy administration**
- **Physical therapy**
- **Occupational therapy**
- **Speech therapy**
- **Respiratory therapy**
- **Factor 8 injections**
- **Burn therapy**

Treatment/therapy services, are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

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DEC 30 1991
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DEC 01 1991
91-39
A
Supersedes TN 91-28

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician **and nurse practitioner** services
- outpatient hospital therapy and treatment services and related physician **and nurse practitioner** services

For services beyond the 12 visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered to be categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm (code range 140.0 through 208.91); HIV infection (code range 042); renal failure (code range 584.5 through 586) and **pregnancy (diagnosis code range 630 through 677, diagnosis codes V22.0 and V22.1 and diagnosis codes V280 through V289).** All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

STATE Arkansas
DATE REC'D 4-30-99
DATE APPV'D 6-18-99
DATE EFF 7-1-99
HCFA 179 99-04

A

SUPERSEDES: TN - 93-29

2.a Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. The benefit limit for State Fiscal Year 1992 will be calculated beginning with services provided on or after December 1, 1991.

Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician services
- outpatient hospital therapy and treatment services and related physician services

For services beyond the 12 visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered to be categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm (code range 140.0 through 208.91); HIV infection (code range 042.0 through 044.9) and renal failure (code range 584.5 through 586). All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

STATE Arkansas
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DATE EFF NOV 01 1993
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A

Supersedes: TN 91-59